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2. a. Outpatient Hospital Services

1. Reimbursement is based on a fee for service and may not exceed the amount established for any qualified provider for the same service. Laboratory and x-ray services may not exceed the amount established by Medicare for the procedures.

2. Other services specific to hospitals; i.e., emergency room, outpatient surgery, cast room, may not exceed the established Medicare upper limits based on reasonable cost.

b. Rural Health Clinic Services

Payment is made using the encounter rate established for the clinic by the Medicare carrier, as adjusted by the carrier during the reporting period and/or at final settlement.

c. Federally Qualified Health Center Services (FQHC)

1. Reimbursement Methodology

The Medicare rural health clinic payment methodology under 1833(1)(3) of the Social Security Act is used to establish Medicaid payment for FQHC services.

(a) Payment for the core services effective 4-1-90 will be based on the reasonable cost rate per visit established by the Medicare Carrier for the FQHC under Section 1833(f) of the Act.

(b) Other ambulatory services provided by a FQHC and included in the State's Medicaid plan will be reimbursed based on a single rate per visit for the service. The rate will be established by the State agency applying the Medicare methodology and principle to the costs incurred by the clinic in providing the service(s).

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2. Payment Methodology

(a) Core Services:

(1) The all inclusive rate determined by the Medicare carrier at the beginning of the reporting period, and any adjustments during the reporting period, will be paid for each Medicaid clinic visit.

(2) Payments made during a reporting period are subject to reconciliation to assure that the payments did not exceed or were less than the allowable costs for the services furnished to Medicaid recipients. Lump-sum adjustments will be made by the State agency where the payments were less than allowable costs. Where the payment rate exceeded allowable costs, the State agency will arrange for repayment by the clinic.

3. Other Laboratory and X-ray Services

Laboratory Services:

Payment shall be the lesser of 90% of the Medicare established fee or the provider billed charge.

X-Ray Services:

Effective for service provided on and after 11-1-94 the following will apply to the technical component for radiology services:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

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4. b. Early and Periodic Screening, Diagnosis and Treatment Services

Screening services are reimbursed on an encounter rate based on the cost of providing the components of the screening examination, and referral where indicated, for all qualified providers.

c. Family Planning Services and Supplies

1. Family planning clinic services are reimbursed on a cost basis for the clinic including staffing and cost of supplies dispensed to the recipients.

2. Family planning supplies as ordered by a physician and dispensed by a retail pharmacy are reimbursed as a pharmacy service.

5. a. Physicians' Services

An upper limit is established using the relative value for the procedure published in the Health Care consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

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b. Medical and Surgical Services Furnished by a Dentist

Payment will not exceed the upper limit established for the service when provided by a physician, or the provider's customary charge whichever is less.

6. a. Podiatrists' Services

Payment will not exceed the upper limit established for the service when provided by a physician, or the provider's customary charge whichever is less.

b. Optometrists' Services

Payment will not exceed the upper limit established for the service when provided by a physician, or the provider's customary charge whichever is less.

c. Chiropractors' Services

Payment will not exceed the upper limit established by Medicare for the services, or the provider's customary charge whichever is less.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

d. Other Practitioners' Services

Psychologists' Services

Payment will not exceed a fee schedule established from

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usual and customary charge information supplied by the provider community which was analyzed using accepted mathematical principles to establish the mean dollar value for the service, or the provider's customary charge, whichever is less.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

7. Home Health Services

The upper limit for Medicaid reimbursement of home health services shall be the lesser of the 90th percentile of the Medicare established rate for West Virginia Medicaid participating providers of home health services, or the provider charge.

The upper limit for Medicaid reimbursement of home health services for those home health agencies reimbursed on a per discipline basis shall be the lesser of the 90th percentile of the Medicare procedure specific fee established for West Virginia Medicaid participating providers of home health services, or the provider charge.

The upper limit for Medicaid reimbursement of home health services for those home health agencies reimbursed on an all inclusive rate shall be the lesser of the 90th percentile of the provider specific all inclusive rate established for West Virginia Medicaid participating providers of home health services on an individual provider basis, or the provider charge.

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8. **Private Duty Nursing Services**

Payment is based on an hourly rate by skill level; i.e., R.N., LPN, Aide, considering customary charges and rates paid for these services by private insurance, or other state agencies.

9. **Clinic Services**

Payment for services provided by established clinics may be an encounter rate based on all inclusive costs, or on a fee for the services provided in the clinic. Payment not to exceed that allowed for the services when provided by other qualified providers. Payment for free standing ambulatory surgery center services shall be the lesser of 90% of the Medicare established fee or the provider billed charge.

School Health Services - Personal Care

Reimbursement for Personal care services shall be fee-for-service. Reimbursement interim rates are based on statewide historical costs for personal care services. Per diem reimbursement shall be available when services are appropriately documented, pursuant to Medicaid billing requirement, and personal care services furnished to the recipient in a given day equal or exceed 6 (six) hours. Costs not to exceed actual, reasonable costs and must be cost settled on an annual basis.

School Health Services - Health Needs Assessment and Treatment Planning

Reimbursement for health need assessment and treatment planning shall be fee-for-service. Reimbursement interim rates are based on statewide historical costs. Services must be appropriately documented, pursuant to Medicaid agency billing requirements. Separate reimbursement rates are available for the comprehensive, triennial assessment and the annual assessment. Costs not to exceed actual, reasonable costs and must be cost settled on an annual basis.

School Health Services - Care Coordination

Reimbursement for care coordination shall be fee-for-service. Reimbursement interim rates are based on statewide historical costs for care coordination services. Monthly reimbursement shall be available when care coordination services are appropriately documented, pursuant to Medicaid billing requirements. Costs not to exceed actual, reasonable costs and must be cost settled on an annual basis.

For description of services see ATTACHMENT for A, D, and E of Supplement 1 to Attachment 3.1-A

10. **Dental Services**

An upper limit is established by procedure using the 1990 survey of National and Regional dental fees conducted by the American Dental Association (ADA). Any differential allowed in the survey for specialty practice was eliminated. An inflation factor of 10 percent was added to the survey fees to account for increased costs during the two year period after the survey was conducted.

Certain procedures included in the survey are not covered for payment as they are considered to be antiquated or subject to abuse or misuse. Payment for other covered procedures may be limited in frequency or number of occurrences.

Payment will not exceed the provider's customary charge to the general public.

Effective 11-1-94 the following methodology will apply for services provided by doctors of dental surgery and dental

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medicine; oral and maxillofacial surgeons:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

11. a. Physical Therapy

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

Effective with services provided on and after 11-1-94 the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

b. Occupational Therapy

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

Effective with services provided on and after 11-1-94 the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge

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for the service to the general public.

c. Services for Individuals with Speech, Hearing and Language Disorders

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

NEW — Assistive/Augmentative Communication Devices (ACD)

Reimbursement for the purchase of an Assistive/Augmentative Communication Device will be made at a negotiated percentage of the provider's usual, reasonable and customary charge. Payment will not exceed the provider's charge for the device to the general public.

Monthly rental payments will be made at the provider's usual and customary monthly rental charge.

When a rental device is the same make and model as the ACD that is subsequently authorized for purchase all rental payments made for that rental device will be deducted from the purchase payment authorized.

Reimbursement for training in the use of an augmentative communication device will be made to a qualified speech/language pathologist, trained in augmentative communication devices and services, at the lesser of the established Medicaid rate for the service or the provider's usual, reasonable and customary charge to the general public.

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for the service to the general public.

c. Services for Individuals with Speech, Hearing and Language Disorders

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

For services provided on and after 11-1-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

d. Speech Therapy

An upper limit is established by procedure using a survey of Medicaid coverage conducted by the American Speech, Language, Hearing Association; Medicare upper limits published in the Federal Register 3/21/91; and data compiled from state providers by geographical regions.

12. a. Prescribed Drugs

Reimbursement for prescription drugs shall be the lower of the cost of the drug as defined in paragraphs A and B, plus a reasonable dispensing fee of $3.90, or the usual and customary charges to the general public, including any sale price which may be in effect on the date of the service.

Reimbursement for program drugs is based on the following methodology:

A. Multiple Source Drugs: The upper limit for reimbursement for all multiple source drugs listed in the Federal regulation at 42 CFR 447.332, and listed in the State Medicaid Manual, Part 6, will be the lower of the established specific upper

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limit per unit or the average wholesale price plus a reasonable dispensing fee or the provider's usual and customary charges to the general public.

EXCEPTION: The maximum allowable cost shall not apply in any case where a physician certified in his/her own handwriting that in his/her medical judgment a specific brand is medically necessary for a particular patient. The notation "brand necessary" or "brand medically necessary" must be written on the prescription by the physician as defined in West Virginia Code 30-5-12(b).

All such certified prescriptions must be maintained in the pharmacy files and made available for inspection by the United States Department of Health and Human Services or the State agency.

B. Other Drugs: The upper limit for reimbursement for other drugs will be the lower of the established acquisition cost (EAC) plus a reasonable dispensing fee or the provider's usual and customary charges to the general public. The estimated acquisition cost (EAC) of each drug will be the average wholesale price less 12 percent from the current price in effect on the date of service plus a reasonable dispensing fee. The reference price for average wholesale price (AWP) will be as listed in First Databank or other designated National Drug Pricing publications.

C. Compounded Prescriptions: Payment will be based upon the average wholesale price (AWP) less 12 percent from the current price in effect on the date of service for each ingredient, one of which must be a legend item. A fee of $1.00 will be added to the reasonable dispensing fee for the extra compounding time by the pharmacist.

D. Assurances: Payment for multiple source drugs identified and listed in the State Medicaid Manual, Part 6, will not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee plus an amount established by HCFA that is equal to 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size, as required in 42 CFR 447.332(a)